



Healthy Indiana Plan 2.0: Enrollment, Redetermination, and Conversion



Objectives

- ✓ After reviewing this presentation you will understand:
 - HIP 2.0 features, options, benefits, and cost sharing
 - How to enroll into HIP 2.0
 - Insured groups transitioning to HIP 2.0
 - How transition will work
 - HIP 2.0 eligibility redetermination

Terminology

| | |
|---|--|
| Cost Sharing | The costs a member is responsible for paying for health services when covered by health insurance. |
| Deductible | A form of cost sharing. A deductible is a dollar amount that pays for initial medical costs before health insurance starts to pay. HIP 2.0 has a \$2,500 deductible that is funded by a combination of state and member contributions. |
| Copayment | A form of cost sharing. Copayments or “copays” refer to a specific dollar amount that an individual will pay for a particular service, regardless of the total cost of the service accessed. The payment may be collected at the time of service or billed later. The HIP Basic plan requires copayments for most services from \$4 for a doctors visit or prescription to \$75 for a hospital stay. |
| Federal Poverty Level (FPL) | Determined annually by the federal government. The federal poverty level for 2014 is \$973 per month for an individual and \$1,988 per month for a family of four. 75% of the federal poverty level is equal to .75 x the federal poverty level for the family size. |
| Affordable Care Act | Federal law passed in 2010, requires most individuals to have health insurance or face a tax penalty. |
| Federal Health Insurance Marketplace | Individuals with income over the federal poverty level can purchase insurance plans through the federal government’s Health Insurance Marketplace. Those with incomes between 100% and 400% FPL may receive federal tax subsidies to help pay for coverage. |
| Preventive Services | Health care services recommended to identify health conditions so they can be treated before they become serious. |

HIP 2.0: Basics

Who is eligible for HIP 2.0?

- Indiana residents*
- Age 19 to 64*
- Income **under 138%** of the federal poverty level (**FPL**)*
- Not eligible for Medicare or other Medicaid categories*
- Also includes individuals currently enrolled in:
 - Family planning services (MA E)
 - Healthy Indiana Plan (HIP)
 - Hoosier Healthwise (HHW)
 - Parents and Caretakers (MAGF)
 - 19 and 20 year olds (MA T)

Monthly Income Limits for HIP 2.0 Plans

| # in household | HIP Basic Income up to 100% FPL | HIP Plus Income up to ~138% FPL** |
|----------------|------------------------------------|--------------------------------------|
| 1 | \$973 | \$1,358.10 |
| 2 | \$1,311 | \$1,830.58 |
| 3 | \$1,650 | \$2,303.06 |
| 4 | \$1,988 | \$2,775.54 |

*Adults not otherwise Medicaid eligible who have children must make sure their children have minimum essential coverage to be eligible for HIP

**133% + 5% income disregard, income limit for HIP program. Eligibility threshold is not rounded.

HIP 2.0: Plan Options

Best
Value

HIP Plus

- Initial plan selection for all members
- **Benefits:** Comprehensive, including vision and dental
- **Cost sharing:**
 - Must pay affordable monthly POWER account contribution: Approximately 2% of member income, ranging from \$1 to \$100 per month
 - No copayment for services*

HIP Basic

- Fall-back option for members with household income less than or equal to 100% FPL only
- **Benefits:** Meet minimum coverage standards, **no vision or dental coverage**
- **Cost sharing:**
 - May not pay one affordable monthly POWER account contribution
 - Must pay copayment for doctor visits, hospital stays, and prescriptions

HIP State Plan

- Individuals who qualify for additional benefits
- **Benefits:** Comprehensive, with some additional benefits including vision and dental
- **Cost sharing:**
 - HIP Plus OR HIP Basic cost sharing

HIP Link

- ***More information coming soon!***
- To help member pay for employer-sponsored health insurance

*EXCEPTION: Using Emergency Room for routine medical care

HIP 2.0: Plan Options

HIP Plus

Offers best value for members.

Comprehensive benefits including vision and dental.

To be eligible, members pay a monthly contribution towards their portion of the first \$2,500 of health services.

Contributions are based on income – approximately 2% of household income per year – ranging from \$1 to \$100 per month.

No copayment required when visiting doctors or filling prescriptions.

HIP Basic

Fallback option for lower-income individuals.

HIP Basic benefits that cover the essential health benefits but not vision or dental services for adults.

Members pay between \$4 and \$75 for most health care services.

Receiving health care is more expensive in HIP Basic than in HIP Plus.

HIP Link

Coming Soon!

Members receive help paying for the costs of employer-sponsored health insurance.

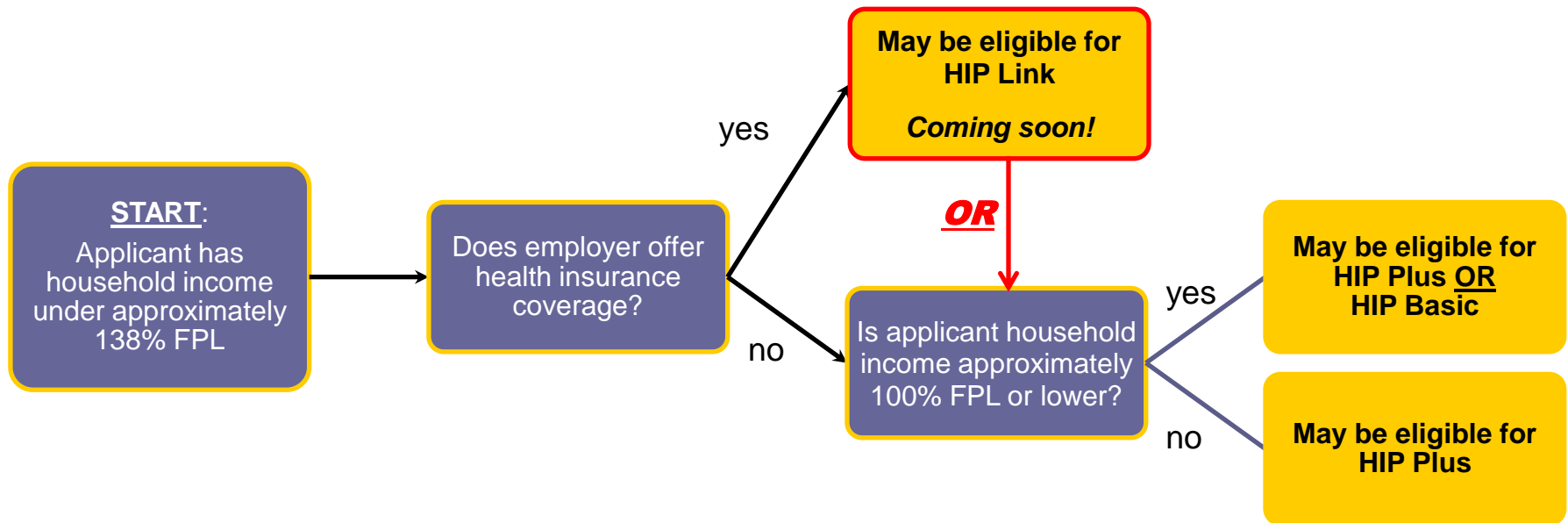
Members with a **qualified and participating** employer are eligible for the employer-sponsored health insurance.

Member may choose HIP Link or other HIP plans.

HIP Link will be an option on the coverage application.

Other benefit and cost sharing options: Individuals who qualify may receive additional benefits through the HIP State Plan Basic & HIP State Plan Plus options, or have cost sharing eliminated per federal requirements.

Income Eligibility for HIP 2.0 Plans



Monthly Income Eligibility Thresholds

| # in household | Income up to 100% FPL | Income up to ~138% FPL * |
|----------------|-----------------------|--------------------------|
| 1 | Up to \$973 | Up to \$1,358.10 |
| 2 | Up to \$1,311 | Up to \$1,830.58 |
| 3 | Up to \$1,650 | Up to \$2,303.06 |
| 4 | Up to \$1,988 | Up to \$2,775.54 |

*133% + 5% income disregard, income limit for HIP program. Eligibility threshold is not rounded.

POWER Account

- ✓ Unique feature of the Healthy Indiana Plan (HIP)
- ✓ Health savings-like account
 - Members receive monthly POWER account statements
 - Used to pay for the first \$2,500 of service costs
- ✓ HIP Plus:
 - Members make monthly contributions to POWER account
 - Contribution amount is approximately 2% of income
 - Contribution ranges from \$1 to \$100 per month
 - Members exempt from most other cost sharing
- ✓ If members leave the program early they may still receive invoices for unpaid POWER account contributions from their health plan, depending on the cost of health care services received
- ✓ **Rollover.** All members may reduce future HIP Plus POWER account contributions
 - Must have remaining contribution in POWER account and/or
 - Receive required preventive services

HIP 2.0 – APPLICATION & ENROLLMENT

Applying for HIP 2.0

- ✓ HIP 2.0 coverage timeline contingent on federal approval:
 - Assess all applications received in late 2014 for HIP 2.0 eligibility
 - Coverage targeted to begin in 2015
- ✓ **Application Methods:**
 - Indiana Application for Health Coverage
 - Eligibility considered for all Indiana Health Coverage Programs (IHCP), including HIP 2.0
 - **HIP 2.0 will not use the separate HIP application,**
 - Apply for HIP 2.0 with the Indiana Health Coverage Application
 - Presumptive Eligibility application
 - Apply with qualified hospitals for temporary coverage
 - Applicants must complete Indiana Application for Health Coverage to maintain eligibility
 - Federal Health Insurance Marketplace
 - Eligibility considered for Qualified Health Plans, premium tax credits, cost sharing reductions, and IHCP
 - If assessed potentially eligible for HIP 2.0, application data will be sent to Indiana's Division of Family Resources (DFR)
 - DFR will assess for IHCP eligibility, including HIP 2.0

Application Features: Gateway to Work

HIP 2.0 applicants and members referred to existing State workforce training programs and job search resources if:

- ✓ Unemployed or working less than 20 hours per week **AND**
- ✓ Not full-time students

Notes:

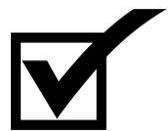
SNAP recipients who have already been sent to Gateway to Work will not be referred again

Not participating in the Gateway to Work program does not impact HIP 2.0 eligibility

Application Features:

Selecting a Managed Care Entity

- ✓ Indiana Application for Health Coverage will offer choice of three managed care entities (MCE) and applicants choose:



Anthem



MDwise



MHS

- ✓ Selecting a MCE
 - Doctors and hospitals may vary by MCE
 - RECOMMEND: Ask preferred doctor(s) to ensure MCE coverage
 - Selection assistance available from MAXIMUS
 - 1-877-GET-HIP-9 (1-877-438-4479)
 - Able to answer questions about MCEs
 - If no selection made, MCE will be auto-assigned

Selecting a Managed Care Entity

Select or auto-assign managed care entity (MCE)

Member can change MCE any time before paying POWER account contribution (PAC)

Decision to change MCE does not provide additional time to make PAC

Pay POWER account contribution (PAC) to MCE

If PAC made to incorrect MCE, may correct, but must do so within 60 day time limit

HIP 2.0 coverage begins

When Individuals Can Change Managed Care Entity (MCE)

✓ Individuals may change MCE:

At determination

- **After** assessed eligible for HIP
- **Before** paying POWER account contribution (PAC)

During Presumptive Eligibility period

- **After** qualified hospital assesses presumptively eligible for HIP
- **Before** paying PAC

When just cause

- **After** PAC paid
- Just cause reasons include (but are not limited to):
 - Lack access to medically necessary covered services
 - Lack access to providers experienced in dealing with member health care needs
 - Poor quality of care, including failure to comply with established standards of medical care

At redetermination

- **After** reassessed eligible for HIP
- **Before** paying PAC

**For more information about changing MCE, contact
1-877-GET-HIP-9 (1-877-438-4479)**

HIP Plus Enrollment

Applicant
determined
eligible for HIP
2.0

Applicant receives bill from
selected / auto-assigned
managed care entity
(MCE)

Considered a *conditional
HIP member*

60 days to pay POWER
account contribution (PAC)
to MCE

Conditional
member pays
first PAC to
MCE

Enrolled in
HIP Plus

HIP Plus
benefits begin
the month of
first payment

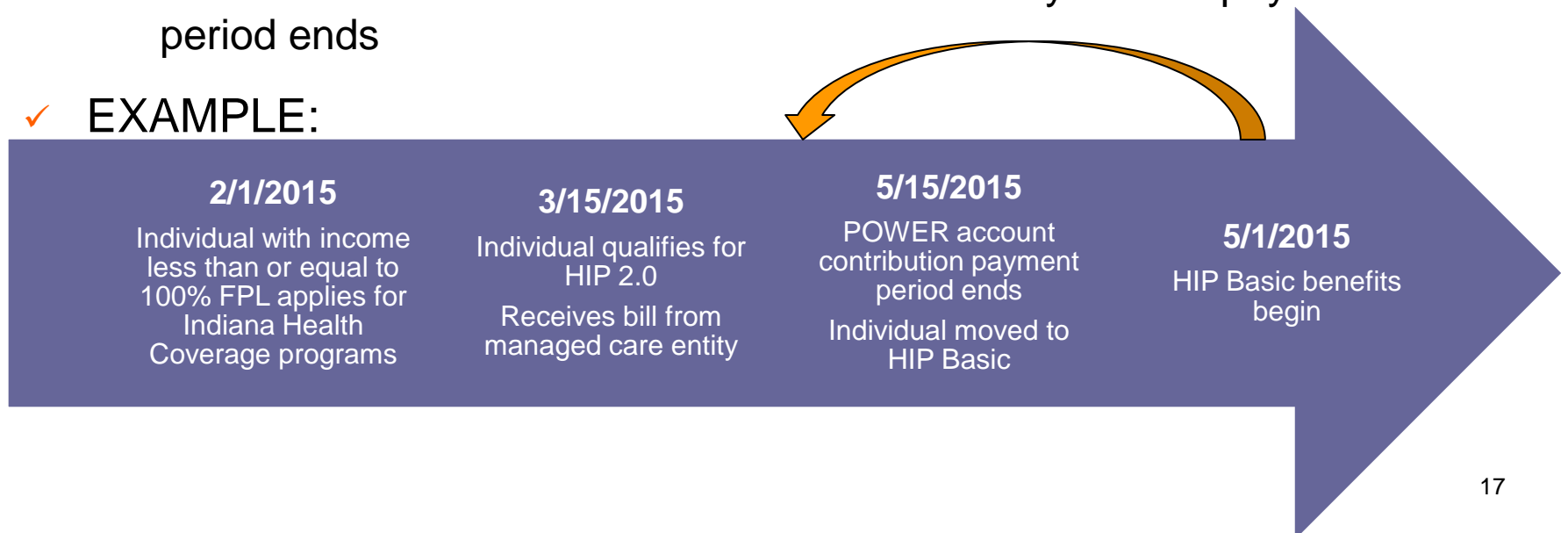
Retroactive Coverage

- ✓ HIP 2.0 does not provide coverage for:
 - The months before the initial POWER account contribution is (PAC) paid *or*
 - The months prior to when an individual defaults into HIP Basic
- ✓ Prior to HIP 2.0 implementation:
 - Current Medicaid eligibility rules apply

HIP Basic Enrollment

- ✓ HIP Basic available for individuals:
 - With income less than or equal to 100% FPL **AND**
 - Who do not make the HIP Plus required contribution within 60 days
 - May not call and ask to be enrolled in HIP Basic prior to the end of the 60 day payment period
- ✓ HIP Basic coverage:
 - Effective the 1st of the month in which the 60 day invoice payment period ends

- ✓ **EXAMPLE:**



Moving to HIP Plus

- ✓ Members may move from HIP Basic to HIP Plus
 - During annual redetermination
 - During POWER account rollover period

Enrollment for Individuals with Income Greater than 100% FPL

✓ Access to HIP Plus

- Make POWER account contributions (PACs) to enroll and remain enrolled
- No benefits received until the first of the month the initial payment made

Dis-enrolling from HIP 2.0

- ✓ Common reasons individuals dis-enroll from HIP
 - No longer eligible for HIP
 - Became eligible for Medicare
 - Became eligible for other Medicaid category
 - E.g. Disability, Aged, Pregnant, etc.
 - Income increased to over 138% FPL
 - Moved out of state
 - Failed to complete redetermination
 - HIP Plus members who do not pay monthly POWER account contribution within 60 days
 - Members with income less than or equal to 100% FPL automatically enrolled in HIP Basic
 - Members with income greater than 100% FPL dis-enrolled from HIP and subject to a 6 month lockout period
 - **Exceptions:** Native Americans, Transitional Medical Assistance, Medically Frail, Pregnant women, Individuals living in a domestic violence shelter, Individuals in a state-declared disaster area

Dis-enrolling from HIP 2.0 (cont.)



- ✓ POWER account contributions after dis-enrolling
 - Members leaving the program early may receive a refund for any unused contribution
 - Reporting a change that makes them ineligible for HIP (e.g. move to a different state): 100% of remaining member contribution
 - For non-payment of POWER account contribution: Amount will be reduced by 25%

Lockout Periods

- ✓ Medicaid eligibility during lockout periods
 - Individuals who submit a new application during their HIP lockout period will have their eligibility considered for Medicaid categories, but will not be eligible for HIP
- ✓ HIP Members are subject to a 6 month lockout period* if:
 - They were HIP Plus members receiving benefits **AND**
 - Have income greater than 100% FPL and less than ~138% FPL **AND**
 - Failed to make POWER account contribution
 - Members have 60 days after the due date to pay POWER account contribution before being locked out of the program
 - If locked out, application data forwarded to the federal Health Insurance Marketplace
 - **OR** they fail to submit their redetermination paperwork on time

*EXCEPTIONS: Individuals who are 1) medically frail, 2) living in a domestic violence shelter, and/or 3) in a state-declared disaster area. If an individual locked out of HIP becomes medically frail, he/she should report the change to his/her former health plan to possibly qualify to return to HIP early.

HIP 2.0 – REPORTED CHANGES

Reporting Changes

Why report changes?

- Change may impact member eligibility and/or benefits

Where are changes reported?

- The Division of Family Resources
- EXCEPTION: Report medically frail status changes to health plan

Who must report changes?

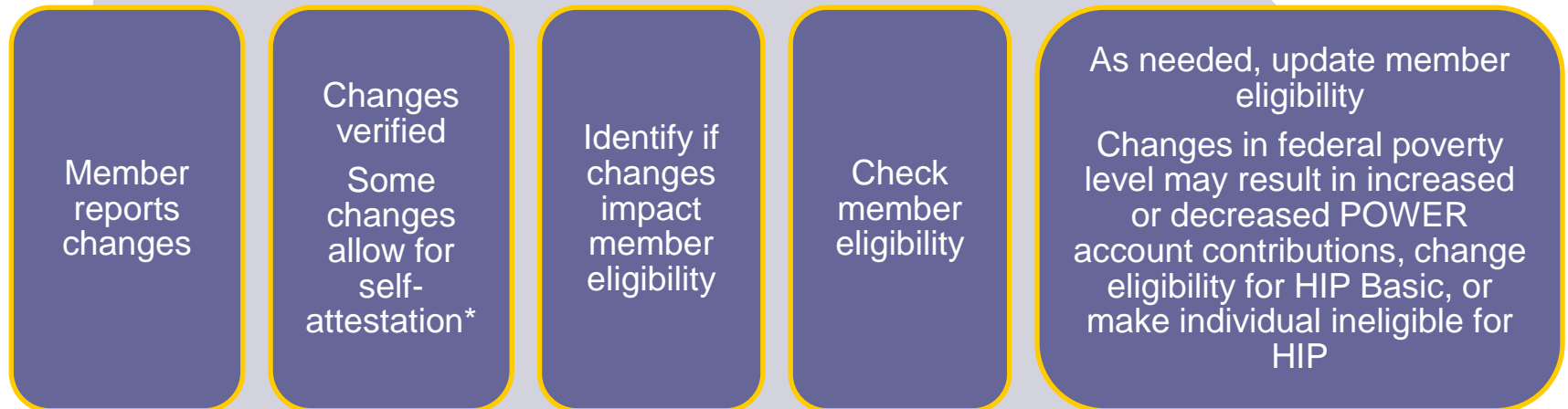
- HIP 2.0 member **OR**
- Member's authorized representative

What types of changes should be reported?

- Family size
- Income
- Address
- Employment
- Pregnancy
- Insurance coverage, including Medicare
- Etc.

If a member reports a change in income over HIP 2.0 eligibility limits, his/her application will be sent to the Health Insurance Marketplace

Verified Member Changes



*Self-attestation is allowed for some changes, in accordance with Indiana's ACA/MAGI eligibility policies

Impact of Verified Member Changes

Verified increase in income

- **HIP Plus members:**
 - May need to pay more in POWER account contribution (PAC)
- **HIP Basic members:**
 - May no longer be eligible for HIP Basic
 - May need to move to HIP Plus and make PAC
 - Will be dis-enrolled if PAC not received
- **All:**
 - No longer eligible for HIP 2.0 if income over ~138% FPL
 - Application data will be sent to the federal Health Insurance Marketplace

Verified decrease in income

- **HIP Plus members:**
 - May not need to pay as much in POWER account contributions
 - May be able to access HIP Basic if miss POWER account contribution

Changes not reported in a timely manner

- **HIP Plus members** subject to benefit recovery

HIP 2.0 - REDETERMINATIONS

Annual Eligibility Redetermination

- ✓ On an annual basis, HIP members required to have eligibility reassessed
- ✓ If eligibility cannot be determined with available information, HIP members receive a redetermination mailer
 - Mailer sent 75 days before the end of the 12 month benefit period
 - If member receives mailer, must complete and return it by the due date
 - **Return mailer on time and determined eligible:** Continue coverage without a coverage gap
 - **Return mailer late:** Late redetermination processing with possible coverage gap

Late Redeterminations

- ✓ Members have 90 days after the coverage end date to return redetermination paperwork and have it processed
 - If paperwork turned in late and member is eligible for HIP but not other Medicaid categories:
 - May have a health coverage gap
 - If paperwork not turned in within 90 days:
 - 6 month HIP lockout period, starting from coverage end date
 - Member must reapply for HIP benefits after lockout period ends, if desire benefits
 - Member application considered for other Medicaid category eligibility, as well

RECOMMENDATION:

To avoid lockout, **all** HIP 2.0 members should complete and submit redetermination paperwork on time

HIP 2.0 - CONVERTING EXISTING MEDICAID MEMBERS

Transition to HIP 2.0

- ✓ **Contingent on federal approval, HIP 2.0 coverage will begin in February 2015 for:**
 - Members currently enrolled* in:
 - HIP
 - Hoosier Healthwise as
 - Low-income Parents & Caretakers (MAGF) or
 - Low-income 19 & 20 year olds (MA T)
 - Family Planning Services (MA E)
 - Individuals applying and eligible for HIP coverage between July 2014 and December 2014
 - Currently placed on a waitlist
 - Pending eligibility verification
 - Individuals applying and eligible for HIP coverage after HIP 2.0 implementation
 - Individuals with income between 100% and 138% FPL who currently have health insurance on the Health Insurance Marketplace

Member Transition Plan to HIP 2.0

| Population | Transition Plan | Member Action |
|---|--|--|
| Current HIP Members with a POWER account contribution (MAHC/MAHN) | HIP Plus, Starting in 2015 | Continue to pay POWER account contribution |
| Current HIP Members with no POWER account contribution (MAHC/MAHN)* | Member receives invoice for HIP Plus. If invoice is paid, member receives HIP Plus; otherwise, if member income is less than or equal to 100% FPL member receives HIP Basic *If PAC not paid in February 2015, these members will receive HIP Basic in February, but may still have time to pay and receive HIP Plus in March | Pay POWER account contribution |
| Current low-income parents and caretakers (MAGF)* | | |
| Current low-income 19 & 20 year olds (MA T)* | | |
| Current Family Planning Services (MA E) | | |
| HIP Waitlist Applicants | Pending verification from member, enrolled in HIP Plus pending a POWER account contribution | Member must submit required information |
| Currently Pregnant Members | No transition to HIP 2.0 until after pregnancy | Notify State of pregnancy end date |

Current HIP Waitlist

- ✓ Applicants unable to enroll in HIP due to program capacity limit are on a waitlist for an available spot
- ✓ The eligibility process still needs to be completed
 - Use electronic means to determine eligibility
 - If unable to determine eligibility through electronic means, a notice and request for additional information will be sent
 - Applicant must submit required information on time
 - If information not submitted on time, applicant sent a denial notice and must reapply to be considered for health coverage

Member Communications

Member Notices

- General conversion notice
 - Sample member notices will be made available online

Web Resource Center

- www.hip.in.gov
 - Member Frequently Asked Questions (FAQs)
 - Eligibility screening guide

HIP 2.0 – HIP LINK

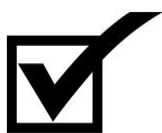
HIP Employer Benefit Link COMING SOON!

✓ **NEW EMPLOYER PLAN OPTION**

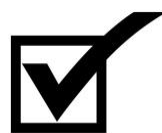
- Families can choose to enroll in employer-sponsored health insurance
- Employer must sign up and contribute 50% of member's premium

✓ **POWER ACCOUNT**

- Member makes contributions to POWER account
- *Defined contribution* from State to allow individuals to
 - Pay for employer plan premiums &
 - Defray out-of-pocket expenses



**Promote family
coverage in
private market**



**Promote HIP
member health
coverage choices**



**Leverage POWER
account potential**

HIP 2.0 - SUMMARY

Summary

- ✓ After reviewing this presentation you will understand:
 - HIP 2.0 features, options, benefits, and cost sharing
 - How to enroll into HIP 2.0
 - Insured groups transitioning to HIP 2.0
 - How transition will work
 - HIP 2.0 eligibility redetermination

***ADDITIONAL ENROLLMENT
PROCESS - HOSPITAL
PRESUMPTIVE ELIGIBILITY (HPE)***

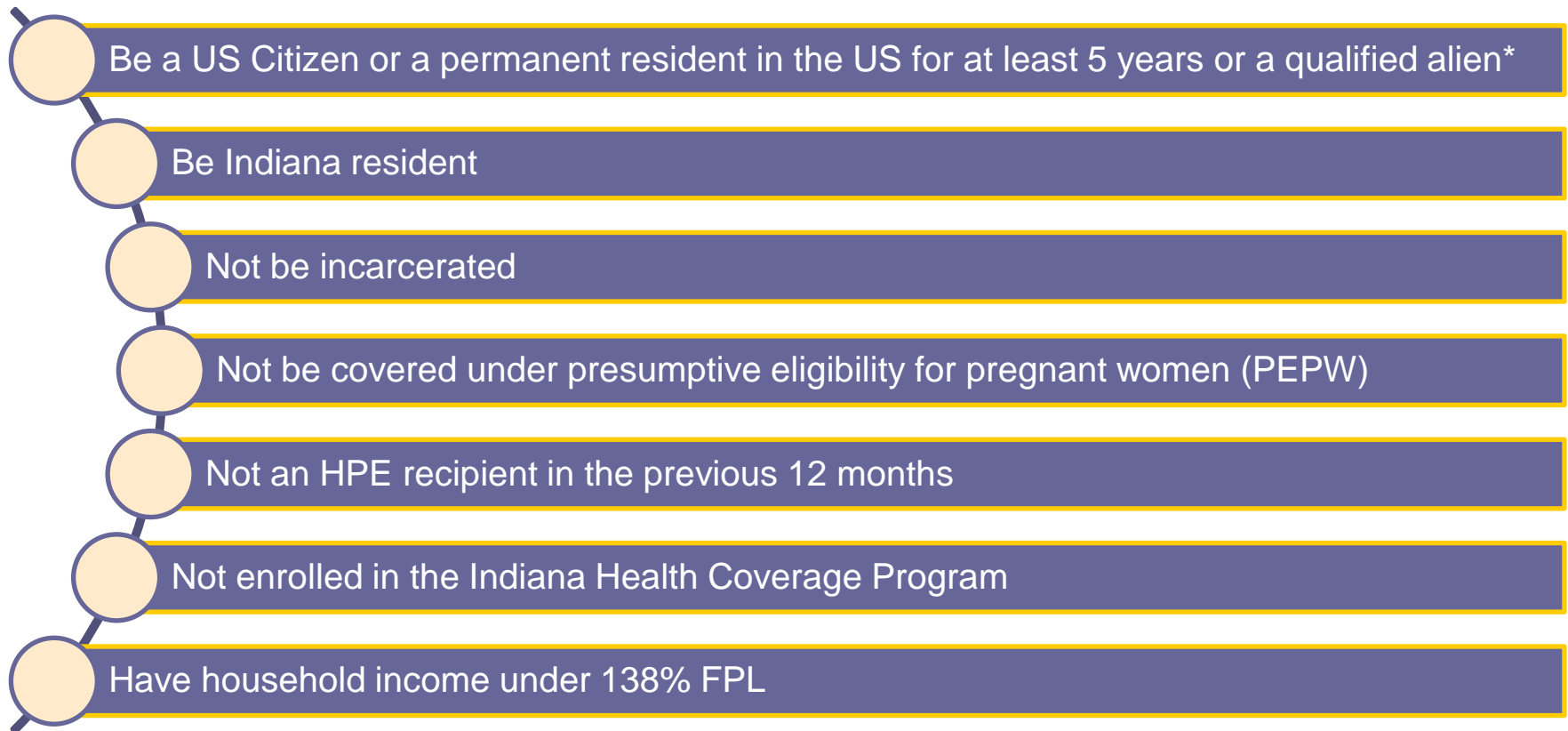
Hospital Presumptive Eligibility (HPE)

- ✓ **Current Hospital Presumptive Eligibility:**
 - Created by the Affordable Care Act
 - Short-term **coverage limited up to 60 days***
 - Hospital participation is optional
 - Participating hospital qualified by the state to take HPE applications
 - Make temporary Medicaid determinations based on questions hospital worker asks applicant
 - Hospital worker may be contracted staff of the hospital
 - Able to assess Medicaid eligibility regardless of whether individual is seeking medical care at the time
- ✓ **HIP 2.0 creates HPE–Adult category for applicants**

*If member completes full application short term coverage will continue through eligibility determination period

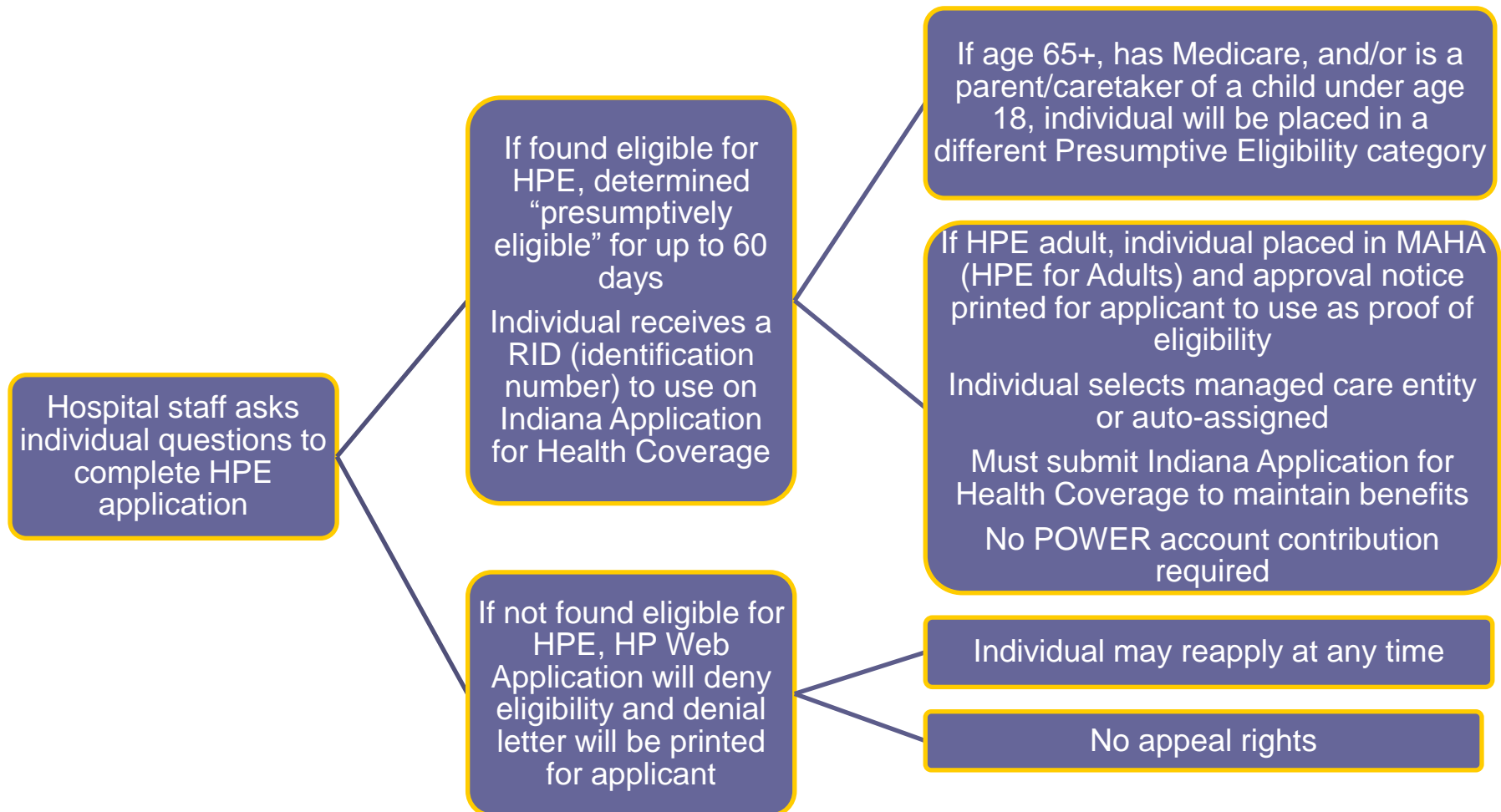
Eligibility for Hospital Presumptive Eligibility (HPE)-Adult

To be determined eligible for HPE-Adult, an individual must:

- 
- Be a US Citizen or a permanent resident in the US for at least 5 years or a qualified alien*
 - Be Indiana resident
 - Not be incarcerated
 - Not be covered under presumptive eligibility for pregnant women (PEPW)
 - Not an HPE recipient in the previous 12 months
 - Not enrolled in the Indiana Health Coverage Program
 - Have household income under 138% FPL

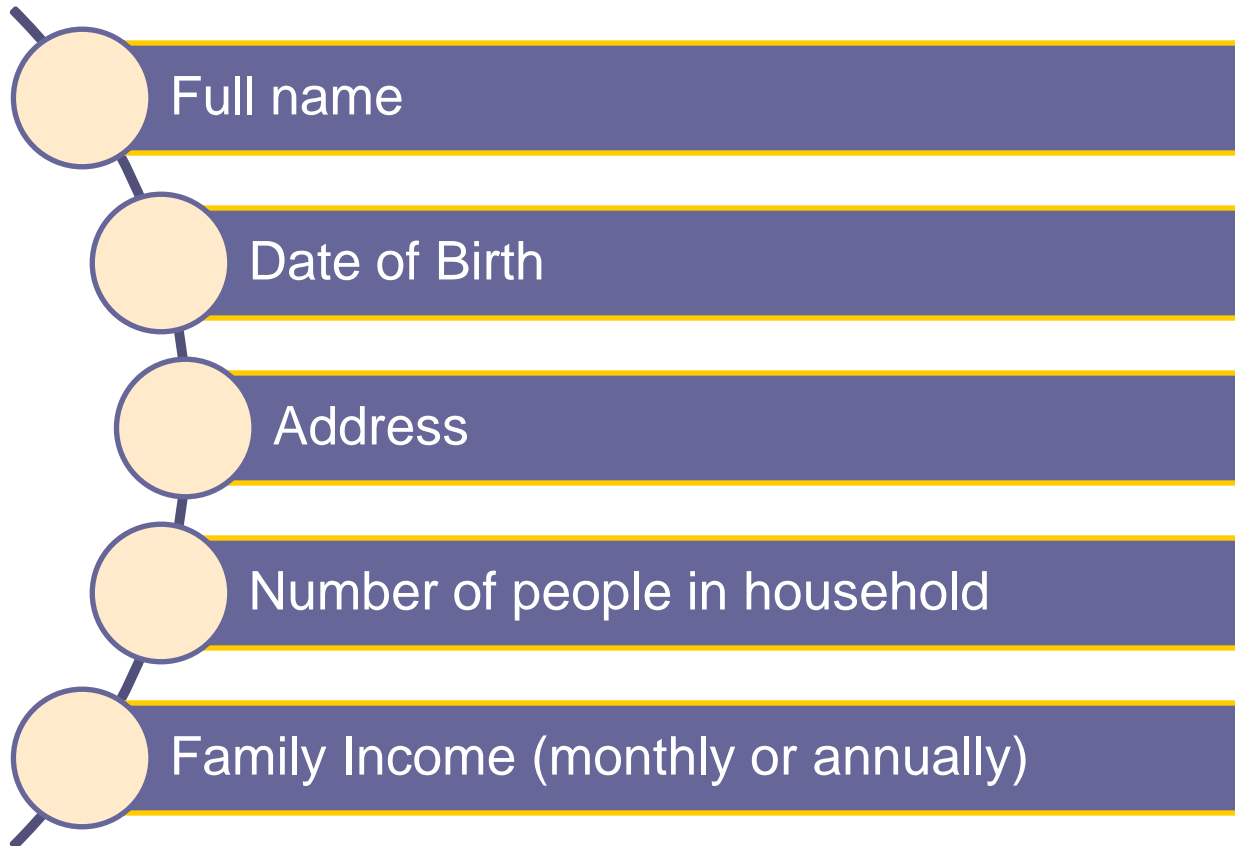
*There are special rules for those that entered the U.S. before Aug 22, 1996

Hospital Presumptive Eligibility (HPE) Process



Hospital Presumptive Eligibility (HPE) Application

- ✓ Required fields on the HPE Application for an eligibility determination to be made are:



Note: Each individual filing for HPE must complete separate application

Hospital Presumptive Eligibility (HPE) Benefits & Cost Sharing

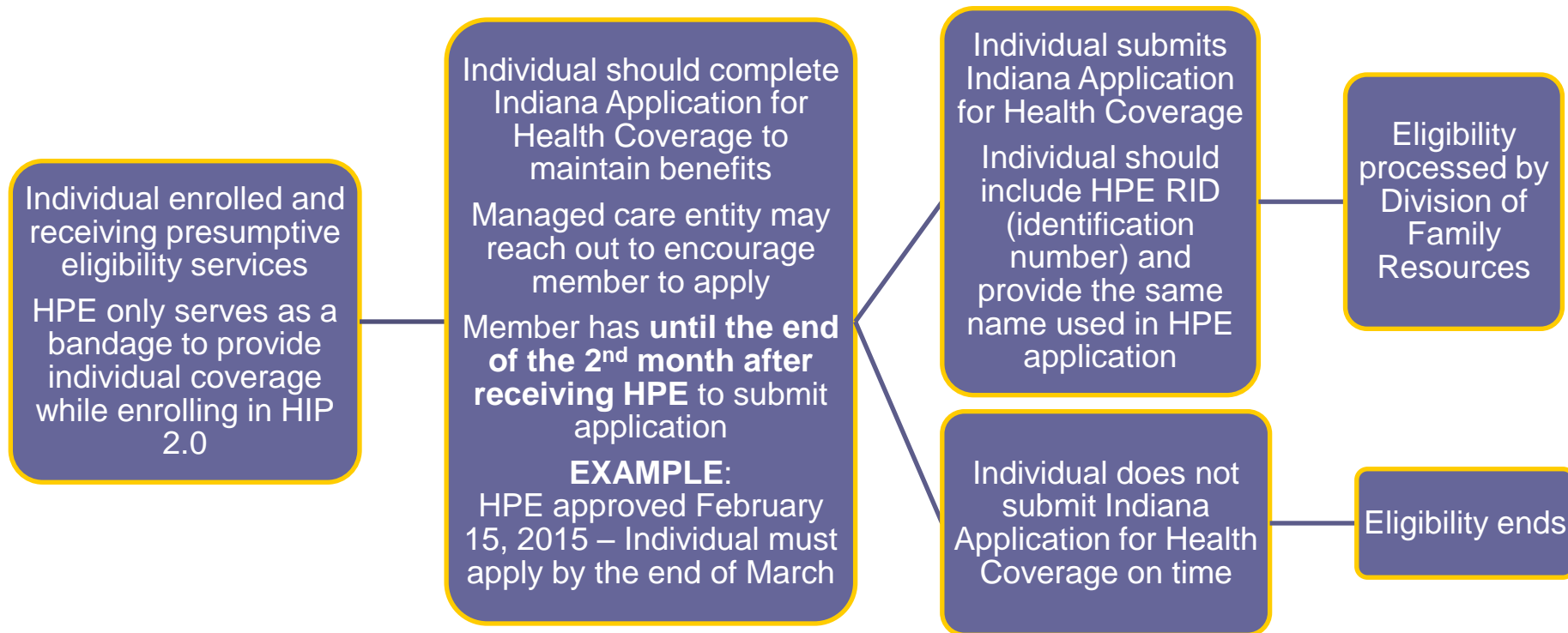
What is the benefit structure for individuals determined eligible for HPE-Adult coverage?

- Presumptive Eligibility (PE) Basic
 - Equivalent to HIP Basic
 - No vision or dental
- Placed into managed care entity
- HPE coverage provided for a maximum of 60 days

What costs will HPE-Adult members need to pay?

- No POWER account created
- Copayments the same as HIP Basic
- Copayment due at point of service

Hospital Presumptive Eligibility (HPE) Member Requirements



Application Processing

| Status for Indiana Application for Health Coverage | Benefits and Next Steps |
|--|--|
| Not submitted | If application not submitted by the end of the month following Hospital Presumptive Eligibility (HPE) approval, HPE coverage (MAHA) closes |
| Pending | Member receives Hospital Presumptive Eligibility (HPE) coverage until determination made by Division of Family Resources |
| Denied | <p>HPE coverage (MAHA) will close the day after denial is processed</p> <p>Member may only receive one HPE period per 12 months</p> |
| Approved | <p>MAHA will close the day after receipt of the eligibility record</p> <ul style="list-style-type: none"> Like all other HIP members, members transitioning from HPE do not have coverage until they: <ul style="list-style-type: none"> Make the first POWER account contribution, OR 60 days have passed and Those with household income less than or equal to 100% FPL move into HIP Basic <ul style="list-style-type: none"> Those with income greater than 100% FPL are locked out |

HIP 2.0 - SUPPLEMENTAL MATERIAL

Primary HIP Eligibility Categories

HIP Plus (MARP)

- Household income up to ~138% FPL
- Best value plan
- Pay monthly POWER account contribution
- No copayments for most medical services

HIP Basic (MARB)

- Household income less than or equal to 100% FPL
- No POWER account contribution
- Pay copayments for most medical services

HIP State Plan Plus (MASP)

- Income under 138% FPL and:
 - Medically Frail, OR
 - Low-income Parents/Caretakers, OR
 - Low-income 19 & 20 year olds OR
 - Transitional Medical Assistance (TMA)*
- Make monthly POWER account contribution

HIP State Plan Basic (MASB)

- Income less than or equal to 100% FPL** and:
 - Medically Frail, OR
 - Low-income Parents/Caretakers, OR
 - Low-income 19 & 20 year olds, OR
 - TMA*

*No household income limit for first six months. Income cannot exceed 185% FPL for additional six months of coverage. Individual may have additional coverage options if also medically frail.

**EXCEPTION: TMA does not have to have income under 100% to be eligible for HIP State Plan Basic

2014 Monthly Income by Federal Poverty Level

| Household Size | 22% | 50% | 75% | 100% | 133% | ~138% FPL* | 200% |
|----------------------------------|-------|---------|---------|---------|---------|------------|---------|
| 1 | \$214 | \$487 | \$730 | \$973 | \$1,294 | \$1,358.10 | \$1,945 |
| 2 | \$289 | \$656 | \$984 | \$1,311 | \$1,744 | \$1,830.58 | \$2,622 |
| 3 | \$363 | \$825 | \$1,237 | \$1,650 | \$2,194 | \$2,303.06 | \$3,299 |
| 4 | \$438 | \$994 | \$1,491 | \$1,988 | \$2,644 | \$2,775.54 | \$3,975 |
| 5 | \$512 | \$1,163 | \$1,745 | \$2,326 | \$3,094 | \$3,248.03 | \$4,652 |
| 6 | \$587 | \$1,333 | \$1,999 | \$2,665 | \$3,544 | \$3,720.51 | \$5,329 |
| 7 | \$661 | \$1,502 | \$2,252 | \$3,003 | \$3,994 | \$4,192.99 | \$6,005 |
| 8 | \$735 | \$1,671 | \$2,506 | \$3,341 | \$4,444 | \$4,665.47 | \$6,682 |
| For each additional person, add: | \$75 | \$170 | \$254 | \$339 | \$450 | \$472.48 | \$677 |

*133% + 5% income disregard, income limit for HIP program. Eligibility threshold is not rounded.